Leicestershire County Council

LEICESTERSHIRE COUNTY COUNCIL

CHILDREN & FAMILY SERVICES

Safeguarding & Performance Unit

Independent Reviewing Officer (IRO) Service Annual R
2019 -2020

Leicestershire County Council

Content

Executive Summary

The Annual Report for the Independent Reviewing Officer (IRO) sets out the current performance for the service in 2018-2019 and identifies our priorities for the forthcoming year. The IRO Handbook (7.11) sets out the requirement for an annual report on the delivery of service and the impact of the IRO service on the outcomes for children in care.

For the purpose of this report, the term LAC (Looked After Child) will be used for statutory related references to children looked after by the local authority for example LAC Reviews, and all other references will refer to Children in Care (CiC).

Key messages within this report are:

Timeliness

Average performance for the year in relation to timeliness of Looked After Children (LAC) Review of Arrangements remains high at 98.4%, as is the case for timeliness of Review Child Protection Conferences (93%) and Initial Child Protection Conferences (95.2%). All of these key performance indicators remain high and well in line with statistical neighbours and national data. This ensures that plans for children are reviewed regularly minimising drift and delay. Service Managers have oversight of all cases that are going to be out of timescale to ensure robust decision making and learning is shared.

Improvements in the timeliness of parents receiving the report before the day of an Initial child protection conference stands currently at 79%.There continues to be room for improvement, but this is continuing the upward trajectory from the previous year. This a key area of performance being driven within Children and Family Services and whilst this is positive to see, it remains a key area of improvement work as the importance of sharing assessments with children and family in a timely manner is critical to effective engagement.

There have been improving process developments within the IRO service in relation to their role for children in care. There have been significant improvements in the backlogs of records for IRO's which in turn has improved the timeliness of distribution and sharing the record of the meeting within 20 working days. IRO's consistently provide the actions of the LAC review within 5 days of the review to support the development of the care plan without drift and delay. Regular audit activity is undertaken to monitor this while a performance report is developed.

There has been positive progress made in minimising the delay in minutes being produced after child protection conferences. There is robust practice in child protection conferences of all participants leaving the conference with the 'mapping' of the meeting and the 'next steps'. This ensures the effective development of the child protection plan in the first core group.

Effective Care Planning

There has been a decrease in the number of child protection plans open over 18 months. This is important as excessive length of plans can evidence drift and delay and lack of impact of the plan. A 6 monthly audit undertaken by the Safeguarding Manager highlights the main contributing factors to this being:

- Consistency of allocated workers i.e. social worker and Child Protection Conference chairs have not changed over this reporting period.
- There is evidence of management oversight by Team managers and Service Managers on some cases which have helped to direct the case.

Participation

The percentage of children participating in their reviews has increased from 86.6% last year to 92.3% this year. It is positive to see there has also been an increase in both the number of children and young people attending their reviews as well as communicating their views in other ways. The engagement of children in their reviews is critical to them understanding their care plan and the decisions and actions around this.

Quality Assurance

A central role of the IRO service is quality assurance across service areas and driving the best outcomes for children and families. During this reporting period the IRO service have had a programme of audit work to support the critical role in supporting quality assurance and improvement. There has been additional quality assurance work undertaken outside this programme following the identification of themes and patterns in performance. The impact of this work is that the unit knows itself well and areas of improvement can be identified both within the unit and for the wider service and action taken to respond in a timely way.

Service Development

Two additional IRO posts have been recruited to with experienced team managers which has strengthened the IRO service further. Additional staffing has also been agreed for 2020-21, which highlights the continued support of senior management for the important role of IRO's in both child protection and for our looked after children population.

Challenges – What are we worried about?

Effective Planning

The improvements in reducing the number of Repeat plans achieved in 2018-19 have not been maintained during this reporting period. We saw a gradual increase in the year to date figure from October 2019 with the final figure being 21.6%. This is now RAG rated red against our target of 19%. We are still lower than our statistical neighbours (22.2%) but higher when comparing with 'Outstanding Shire's' who average at 19.4%. The IROs complete an analysis tool for all incoming repeat plans to enable learning and this is supported by regular quality assurance activity and sharing this across services to develop a holistic response to this declining key performance measure.

Impact of Quality Assurance

There has been steady improvement in the number of Quality Assurance Alerts (IRO escalation process) and an increase in the number of positive alerts which supports our learning from good practice. Despite the increase in numbers, this remains an area for improvement. We have made better progress in evidencing the tracking and footprint of IRO's within LAC cases. However, there continues to be work needed in this being replicated with CP cases so that this demonstrates a visible and timely impact on case planning.

Considering the recommendations from the Ofsted inspection 2019, which highlighted development areas including, consistency of recording, drift and delay in permanence and SMART planning. All of these areas have IRO oversight and the IRO is central to supporting and driving improvement. Therefore, the current numbers of QA alerts do not reflect the robust response that is required from the IRO service to support effective service development.

Timeliness

There has been a reduction in the timeliness of Review Assessments by the social worker being received 24 hours before a LAC Review 76% (2018-19) to 68.3% (2019-20). This needs consistent challenge from IRO's using the Quality Assurance Alert escalation process to highlight themes and responses from teams. The importance of sharing the report in a timely manner

Process Development.

There have been significant improvements in the processes and safeguarding of children presenting with 'Harmful Sexual Behaviour' (HSB). However we are not able to report effectively against the lower level responses and to track the journey of all of the children that are identified along the spectrum of HSB. Further developments within our reporting system Mosaic are required to enable this understanding and will support better reporting of intervention and impact.

Areas for Improvement – What needs to happen

Repeat plans: The Safeguarding Unit will be part of quality assurance activity to understand the reasons behind the increase in repeat plans. IRO's will continue to complete their analysis for repeat child protection conferences to support identifying themes and trends and share the learning. IRO's will be working to ensure that Safety Planning is both evident and tested in child protection planning to ensure that it is robust and embedded well enough to protect children once the child protection plan has ended. IRO role is key to decision making both for plans starting and ending – robust IRO oversight is key to repeat planning being reduced

QA alert process: The implementation of the QA Alert process within our reporting system mosaic will support greater oversight and timely management of alerts of concern which will support better outcomes for children and families. This will also allow better performance data to be captured and build the alert process into the learning cycle more systematically. Management oversight and drive of this role of the IRO is critical to ensuring that it is robust and supports achieving the outcomes set out in the continuous improvement plan

Tableau development: 2019-20 has seen a significant improvement in the timeliness of Review of Arrangement records being completed and distributed, with IRO's having responsibility for uploading the report to mosaic within 20 working days. Development in Tableau (performance reporting tool) for the timeliness of records being completed and the completion of decisions and recommendations within 5 working days, will support management oversight and drive against this performance measure.

Social work reports to meetings: IROs to continue to support and drive forward the improvements in the timeliness of social work reports prior to Review of Arrangements and child protection conferences.

HSB development: Training programme to ensure pool of AIMS3 trained workers to ensure comprehensive and effective offer for children presenting with Harmful Sexual Behaviour. Further development in the recording system 'Mosaic' and performance reporting tool 'Tableau', to enable performance reporting against the journey of all children with HSB identified at the point of contact with Children's Social Care.

1. Introduction

OUR VISION Leicestershire is the best place for all children, young people and their families

This means that we will describe the outcomes we want to achieve for children, young people and their families and identify measures that can tell us how well we are achieving against them. We will aim to be the best performing local authority in the country against these measures, and where we are not yet there we will set stretching targets for annual improvement.

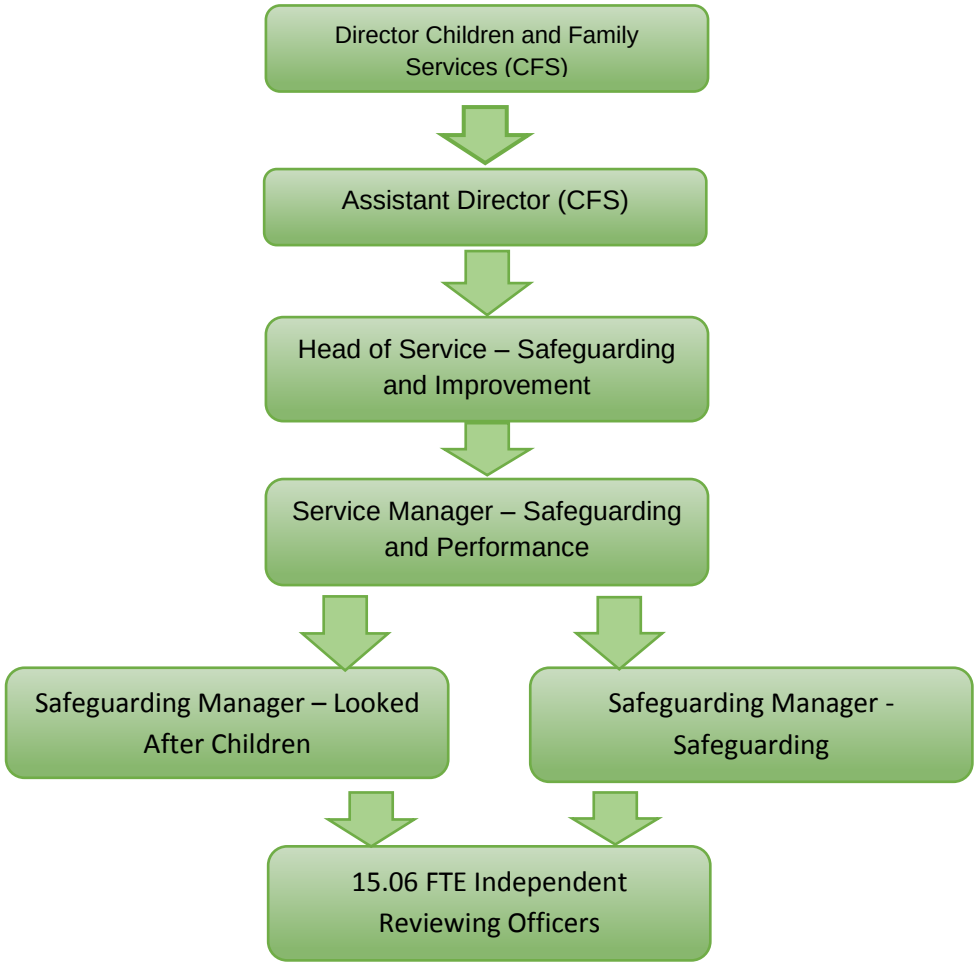
OUR MISSION

Children and young people in Leicestershire are safe and living in families where they can achieve their potential and have their health, wellbeing and life chances improved within thriving communities.

The service provision of the Safeguarding and Improvement Unit is driven by our vision and mission and is underpinned by the shared values of the Children and Family Services

The Annual Report for the Independent Reviewing Officer (IRO) sets out the current performance for the service in 2018-2019 and identifies our priorities for the forthcoming year. The service provision of the Safeguarding and Improvement Unit is driven by our vision and mission statement and is underpinned by the shared values of the Children and Family Services. The role of the IRO service is central to driving forward the Continuous Improvement Plan and promoting the key goals and behaviours set out in the Road to Excellence

The IRO Service in Leicestershire sits within the Safeguarding & Improvement Unit (SIU). Whilst the service sits within the Children and Family Services (CFS) and is part of the management structure of Children's Social Care (CSC); it remains independent of the line management of resources for children in care and the operational social work teams. The independence of the IRO ensures that they are able to advocate and challenge for children and families to receive the right service at the right time to both protect and support them.



IROs have responsibility for both child protection and children in care functions, through their role in child protection conferences and processes, harmful sexual behaviours (HSB) work with children and young people and Looked After Reviews and care planning. All IROs have a combination of Child Protection cases and Looked After Children. Throughout this report both the conference chair and looked after review chair will be referred to as Independent Reviewing Officer (IRO).

The quality assurance role of IROs is critical to the development and improvement of the intervention that we provide to children and families and the impact that we have on the outcomes we achieve. IROs have key duties that scrutinise and support the quality, safety and effectiveness of safeguarding practice and policy, care planning and permanence. IROs are central to identifying and sharing good practice and checking the quality and consistency of provision across the areas of Child Protection and Looked After Children.

IROs have a statutory role to quality assure the care planning and review process for each child in care and to ensure that his/her current wishes and feelings are captured clearly, central to planning and given full consideration. The Children and Young Persons Act 2008 extended the IROs responsibilities from monitoring the performance by the local authority of their functions in relation to a child's review to monitoring the performance by the local authority of their functions in relation to a child's case. Through these changes the IRO has an effective, independent and holistic oversight of the child's case and ensures that the child's interests are protected throughout the care planning process.

This oversight provides opportunity for independent challenge in decisions identified as not being in the best interests of the child or where drift or delay has an impact on outcomes. An effective IRO service will drive forward improved outcomes for children and young people and will ensure that his/her current wishes and feelings are given full consideration.

In Leicestershire, as the IROs also undertake the Conference Chair role, the expectation is that the IRO will apply the same quality assurance approach for children subject to child protection conferences and child protection plans. IROs chair child protection conferences and have oversight of child protection plans and challenge when performance and practice concerns are identified.

This report outlines the contribution made by the IRO Service in Leicestershire, to quality assurance and the improvement of services for children and young people in the care of the County Council and those subject to child protection conferences and

plans during the year April 2019 to March 2020. It is an evaluative report considering how effectively the Safeguarding Until has fulfilled the responsibilities of its role and the impact that this has had on children and families of Leicestershire. It is an opportunity to identify areas of good practice and those in need of development and improvement. It highlights emerging themes and trends, providing information that contributes to the strategic and continuous improvement plans of the local authority. The performance measures used to measure success are both qualitative and quantitative data from all areas of quality assurance undertaken throughout children's services

2. Context

The legal framework and statutory guidance for the IRO role for children in care is set out in the Care Planning, Placement and Case Review (England) Regulations 2010 (amended 2015) and the IRO Handbook 2010.

The Handbook requires an Annual Report to be written and is prescriptive as to content and format (which this report follows) and the expectation that the report is made available for scrutiny by the Corporate Parenting Board, as well as accessible as a public document.

The appointment of an IRO is a legal requirement under S118 of the Adoption and Children Act 2002, their role being to protect children's interests throughout the care planning process, ensure their voice is heard and challenge the local authority where needed in order to achieve best outcomes.

The National Children's Bureau (NCB) research 'The Role of the Independent Reviewing Officers in England' (March 2014) provides a wealth of information and findings regarding the efficacy of IRO services. The foreword written by Mr Justice Peter Jackson; makes the following comment:

'The Independent Reviewing Officer must be the visible embodiment of our commitment to meet our legal obligations to this special group of children. The health and effectiveness of the IRO service is a direct reflection of whether we are meeting that commitment, or whether we are failing'.

Working Together to Safeguard Children 2018 is the statutory guidance that governs the Safeguarding Children's Partnership (LRSCP) procedures and underpins the IRO role for children subject to child protection conference/plan/processes, to work within.

3. IRO Service

Safeguarding and Improvement Unit

1x FTE Service Manager

2x FTE Safeguarding Managers

15.06 x FTE IRO

There are significant benefits of the IRO service being located within Children's Social Care whilst maintaining their independence. The position allows IRO's to have a good understanding of the key performance indicators and the context in which the Local Authority operates. Enabling understanding of the changing demands and pressures in the Department, including the impact of recruitment and retention.

To be successful, the role of the IRO must be valued by senior managers and operate within a supportive service culture and environment. It is not the responsibility of the IRO to manage the case, supervise the social worker or devise the care plan, but to have oversight to ensure that the child's plan is achieving change and creating positive outcomes for children and families.

IROs build constructive working relationships with social work teams and senior managers which are vital to their quality assurance role. Enabling IRO's to have comprehensive oversight of the strengths and needs of the department and utilising the established professional relationships to challenge areas of need and champion good practice. This in turn enables contributions to improvement activity which have a direct impact on improved outcomes for children and families.

The Safeguarding and Improvement Unit continues to be very well supported by senior leaders and this is evidenced in 2019-20 with the addition of 2 permanent IRO's joining the team in December 2019, increasing the structure from 13.06 to 15.06 FTE IRO's . This highlights the recognition of the pivotal role the IRO's have in undertaking statutory duties such as chairing meetings and the broader quality assurance role which supports driving and improving practice. In quarter 1 of 2019-20 there were continued staffing challenges of the Safeguarding administration team, which did impact on the timeliness of some statutory duties such as timeliness of Initial Child Protection Conferences and distribution of Review of Arrangement records. This issue has improved significantly throughout 2019-20 and we ended the financial year with a well-staffed, stable and efficient administration team.

Within the Safeguarding and Improvement Unit a weighting process is applied to analyse caseloads. This process takes into account the two different roles of the

IRO's; chairing Child Protection Conferences and Review of Arrangements and identifies each LAC case as 1.5 cases and CP cases as 1.

The IRO handbook guidelines refer to caseloads for IRO's (only referring to the role with Children in Care) as 50-70 cases. The application of the weighting process makes this 75-105 cases. Over 2019-20 caseloads have continued to be higher than these recommended guidelines with the average case load being 110 (with weighting process applied). This is despite an additional 2 IRO's joining the service towards the end of this reporting period. The increasing numbers of children in care and children subject to a child protection plans has been on an upward trajectory during 2019-20 and this will continue to have an impact on the capacity of the IRO service. This will need to be assessed and analysed moving forward.

Collectively, the IRO service has many years of social work and management experience, professional expertise and knowledge across a number of areas which brings great benefit in their role of working with children and families as well as an ability to offer consultation to the wider department. This includes but is not confined to:

- HSB (Harmful Sexual Behaviours)
- Domestic Abuse Champion
- Neglect
- Children with disabilities and complex care needs
- Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs)
- Youth Offending
- Therapeutic social work
- Fostering, Adoption and Permanency
- Mental Health
- PREVENT & MAPPA
- Modern Slavery.
- Unaccompanied Asylum Seeking Children (UASC)

The quality assurance role of the IRO is central to strengthening the implementation of Signs of Safety which is the practice framework which underpins our work to improve the lives of children and families living in Leicestershire. Therefore it is critical that their Signs of Safety knowledge and skills remain comprehensive. During 2019-20 the IRO service has continued to utilise the bespoke training in Signs of Safety. This training supports the quality assurance role of the IRO's and the progress of embedding Signs of Safety throughout all areas of the work within CFS. These additional training opportunities are continuing into 2020-21 as the department continues to embed the Signs of Safety methodology into its culture and practice.

IROs play a significant role in the development and delivery of high-quality interventions to children in care and in need of protection. The IRO Service in Leicestershire remains committed to this responsibility. This commitment is supported by the implementation of a service specific Learning Audit Framework (2019-20) which highlights areas of need and provides a framework of observation, peer audit and audit analysis to inform learning and drive forward best practice.

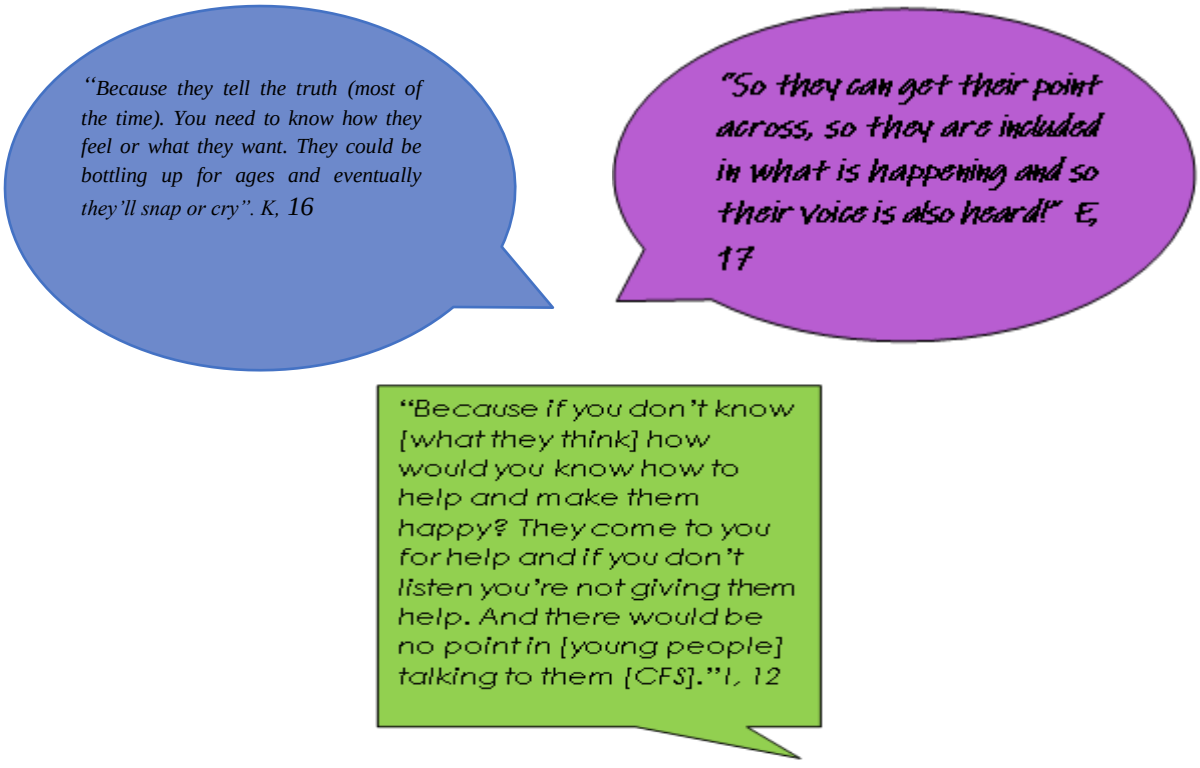
4. Being a Corporate Parent

The IRO Service within Leicestershire operates within the context of the council acting as 'Corporate Parents' for all of the children and young people that are placed in the care of the Local Authority. Looking after and protecting children and young people is one of the most important jobs that councils do and it is the council's responsibility to ensure that our children are given the care, support and stability that they deserve.

Our Corporate Parenting Strategy states:

*We know that we will be successful corporate parents if we really listen to our children and ensure that their views and opinions have meaning in all areas of our decision making, '' **You said. We did''**. The impact of this is seen in the enthusiasm, leadership and effectiveness of our children and their participation in our Children in Care Council, Supporting Young People After Care (SYPAC), our Corporate Parenting Board and many more participation events.*

Below are some quotes from our children about why it is important to listen to them

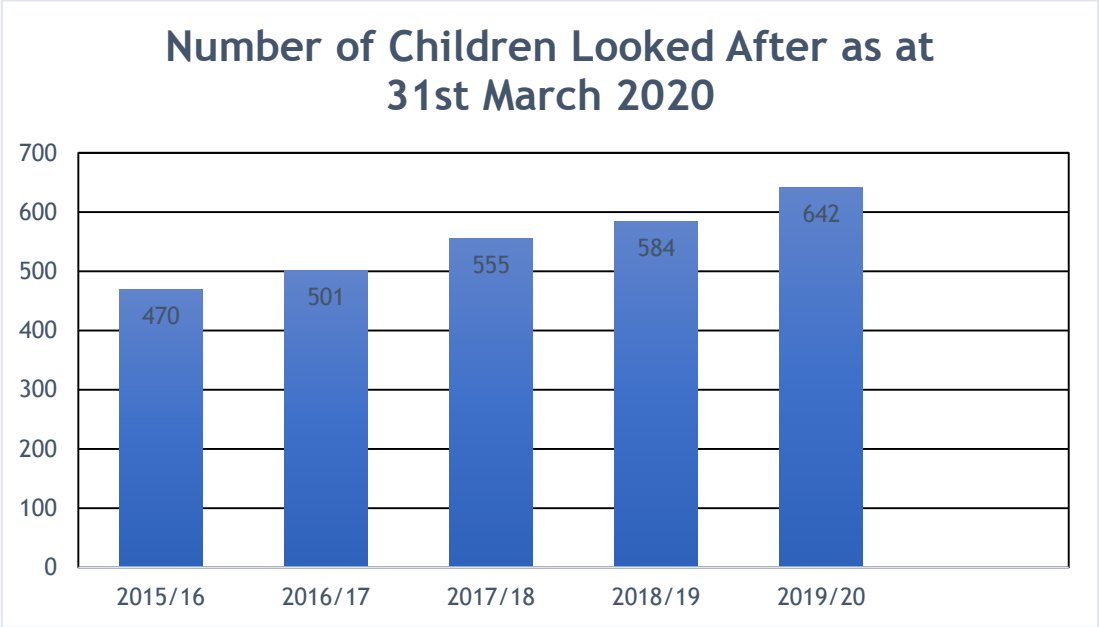


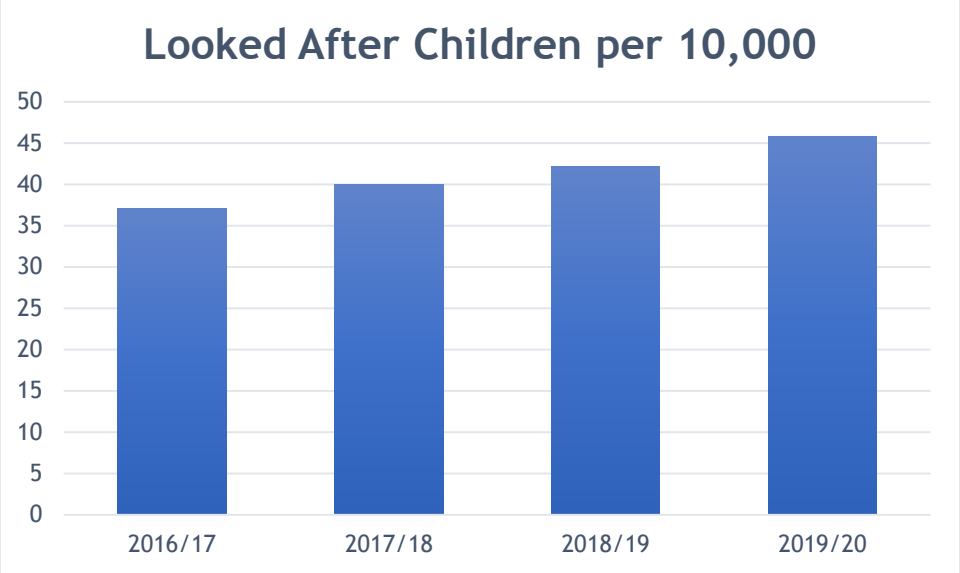
The Corporate Parenting Strategy sets out the responsibilities of Leicestershire County Council as corporate parent to children in care. The Strategy outlines the expectations and key principles that provide the framework for a cohesive and effective corporate parenting response for children in care and Care Leavers. To hold ourselves to account to achieve this Leicestershire developed 'Our Promise' (April 2019) with our children and partners and this underpins the expectations for all.

5. Children in Care - Review of Arrangements

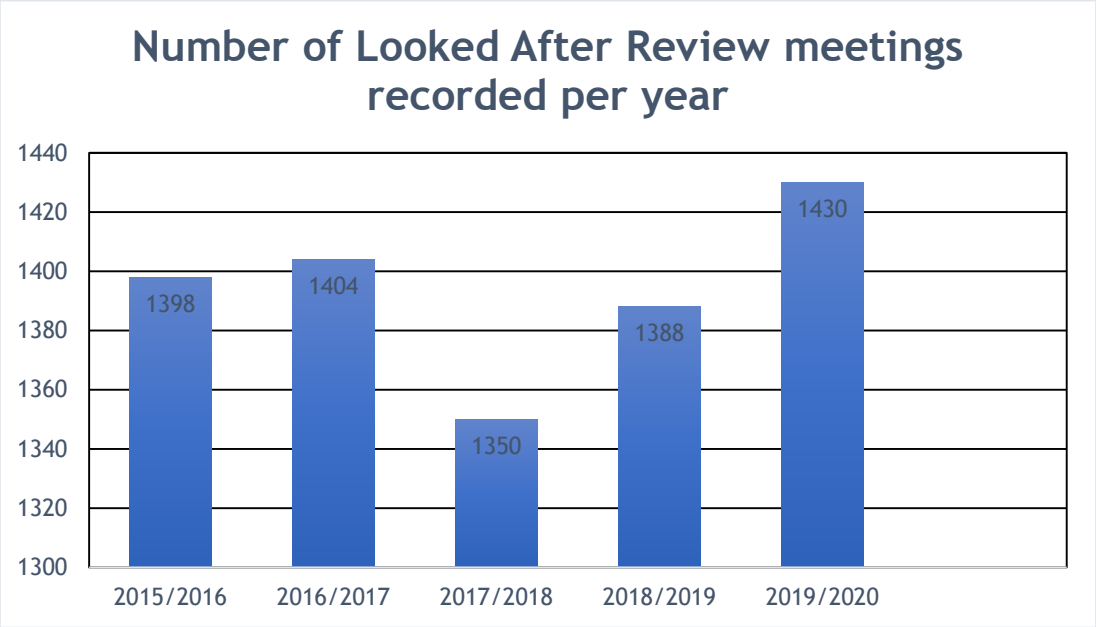
Performance of the IRO Service for Children in Care

As can be seen from the tables below, the children in care population in Leicestershire has increased further over 2019-20, in keeping with a steady year on year increase over the last 6 years. Leicestershire had an increase in looked after population from 584 at the end of March 2019 to 642 at the end of March 2020, this equates to 45.8 looked after children per 10,000 at the end of 2019/20, an increase from 42.2 per 10,000 at the end of 2018/19, this compares with 52.5 for our statistical neighbours as of 31st March 2019.

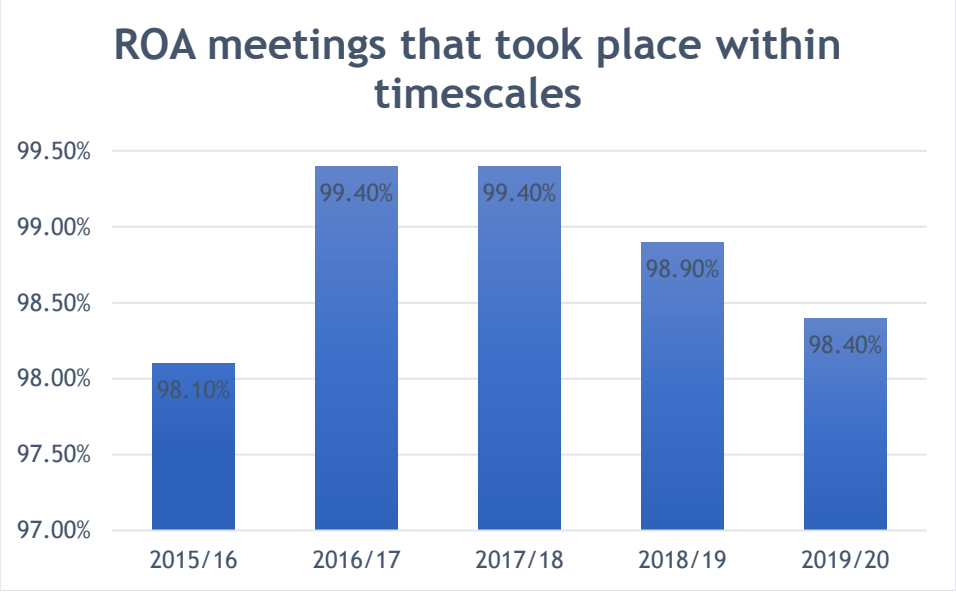




The activity generated from this increase is reflected in the number of Review of Arrangement (ROA) meetings held for children between 1st April 2019 and the end of March 2020 which totalled 1430, this is an increase of 42 meetings from the previous year (NB this is meetings held, not individual children's meetings, for example a sibling group of 3, whose meeting was held together would count as one meeting). In addition to the statutory reviews, IRO's can also arrange additional meetings for a number of reasons; including to review a case earlier due to concerns about drift and delay or because there has been a change in the child's care plan. A meeting is required following change of placement.



Performance in relation to timeliness of ROA meetings remains strong, although there has been a dip of half a percentage point since last year as is illustrated in the table below.



At year ending 31st March 2020 the IRO Service had completed 1430 Review of Arrangement (ROA) meetings for looked after children. Of these 1407 were within timescales which equates to 98.4%. The Safeguarding Unit keep an 'out of date log' to record the reason for each case which does not take place in time. Although performance is slightly down on the previous year of 98.9 % it can still be regarded as strong performance. Of those outside of timescales, eight out of twenty three were 28 Day reviews whereby the child or young person had just come into care and the Safeguarding Unit had not been notified that they had now been looked after, this

was either due to oversight or workers not being familiar with the process of booking in the initial review. This was similar to 2018/2019, it is planned for a step to be put into our recording system mosaic to address this. However, due to competing priorities this has yet to be implemented.

A significant improvement during 2019/20 has been with getting records of Review of Arrangements written up and uploaded onto mosaic in a timely manner. In the previous year this was raised as a concern, therefore a plan was developed to aim to have all records written and uploaded within twenty working days of the review with a minimum target of this being achieved in 95% of cases. In cases where a backlog was identified IRO's worked with managers to plan how this would be addressed including looking at dedicated admin time to clear backlogs. Anecdotally this has been highly successful with the vast majority of ROA's now being written up within timescales although the Tableau management information report to evidence this being consistently achieved has yet to be developed. Safeguarding Managers have oversight of this expectation and respond immediately to poor performance.

Similarly, IRO's now routinely upload all decisions and recommendations from ROA's within 5 working days. This is seen as an important part of the IRO role in ensuring the actions are progressed in a timely way to avoid any drift and delay in getting the right outcomes for a child or young person. Again, the Tableau report to monitor this has yet to be developed however it has been monitored via management dip sampling cases. In the most recent dip sample of 16 cases it was found the in 13 there was either the decisions and recommendations uploaded within 5 working days or the full set of minutes, in all cases the full set of minutes had been uploaded within the required 20 working days.

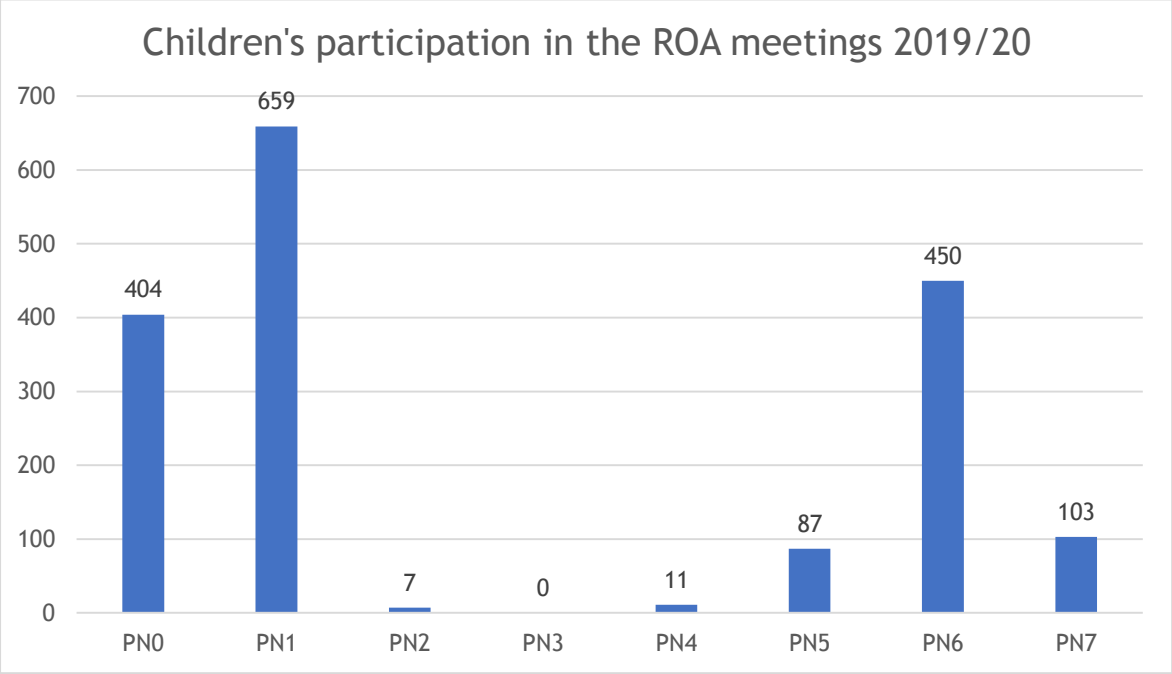
Participation

The child and young person's voice, their views and wishes are essential to the care planning. IRO's continue to strive towards obtaining this and ensuring children and young people actively participate in the review process. Not all children will want to attend a meeting; therefore, IRO's are creative in the ways in which they can support the child in participating, working closely alongside Social Workers and Carers. The IRO service is looking at ways in which this practice can be further developed, including being more creative with Signs of Safety within the review process and promoting active participation. Participation is defined across 8 different indicators:

Number of Children who participated in their review from 2015/16 to 2019/20

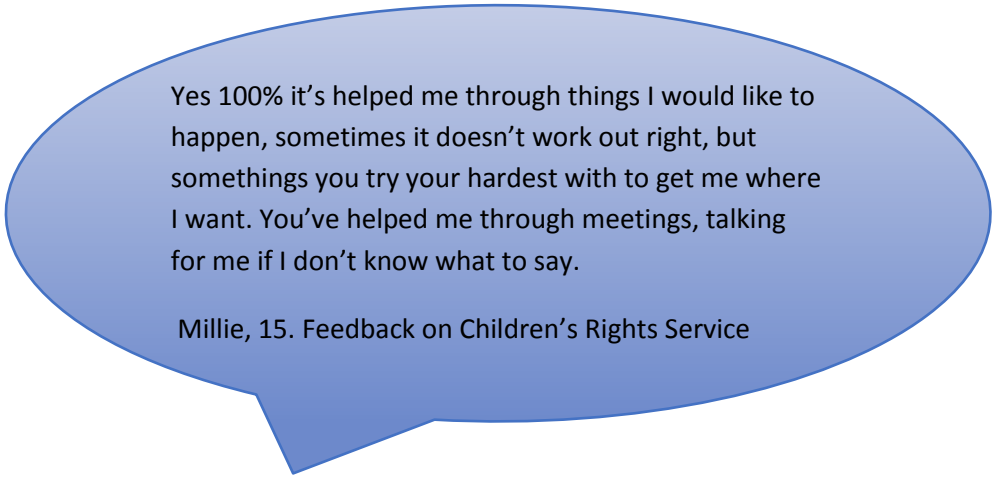
The participation figures for this period are shown in the following table, and the overall percentage represents those children and young people aged 4 and over who communicated their views in some way, for their review.

	2015/16	2016/17	2017/18	2018/19	2019/20
PN0: Children under the age of 4	381	363	363	370	404
PN1: Children who attend their reviews and speak for themselves	522	550	554	632	659
PN2: Those who attend but communicate via an advocate	10	13	4	10	7
PN3: Those who attend and convey their views non-verbally	7	3	2	3	0
PN4: Those who attend but don't contribute	15	4	11	10	11
PN5: Children who do not attend but brief someone to speak on their behalf	74	70	52	98	87
PN6: Do not attend but communicate their views by another method	295	399	415	296	450
PN7: Those who do not attend/convey their views in any other way	100	50	87	163	103



The number of children (over age 4) participating in their reviews has increased from 1,049 (2018-19) to 1214 in the year ending 31st March 2020. Although this is in part due to more children being looked after, more significantly the percentage of children participating in their reviews has increased from 86.6% last year to 92.3% this year. It is positive to see there has also been an increase in both the number of children and young people attending their reviews as well as communicating their views in other ways.

One key method of support for children and young people participating in their reviews is via the Children's Rights Officers (CRO's). IRO's will routinely recommend a referral to the Children's Rights Service if it is felt that this would assist the young person in participation. The CRO will work with the young person and be led by them as to how they want their views represented. This can include being supported in the meeting to speak for themselves, have their views written down using their words and read out by the CRO. This resource is highly valued by IRO's and receives a lot of positive feedback from children and young people.



IRO's have been working to make review meetings more inclusive and thinking creatively with our young people about how they can be supported to chair their own reviews. IRO's always aim to have strong meaningful relationships with the children and young people they work with and as such they have been communicating with young people through a number of mediums including, phone, text and Skype, however most recently the local authority has invested in providing smart phones to all IRO's to enable them to communicate via What's App, a platform which many young people are familiar with which enables them to speak to their IRO via video call. This has proved particularly helpful during the Covid 19 restrictions which began at the end of this reporting period. However, for some young people this has proved to be their preferred means of communication and may continue to be so once all the restrictions are lifted.

Throughout this year children and young people have been encouraged to use the looked after review child consultation booklet to enable them write down their views, thoughts and feelings in advance of the meeting and think about what are the issues that are most important to them which they would like to discuss. This can then be referred to by the young person in their meeting or they can choose to submit it if they felt they did not want to attend their review in person. The use of these booklets may go some way to explaining why this year has seen the highest number of young people being classed as not attending but providing their views in another way.

Listen to them [young people] and act on what they've said. Jess, 17,

"It's crucial that we are listened too, as young people in care can relate to each other's experiences the most and understand what needs to be done".

Children in Care Council member

The voice of children and young people continues' to be a priority within the IRO service and to this end there has been some collaborative work undertaken with the Children in Care Council to look at broadening how children can participate in their reviews and how they can have clear expectations on the way they want their meeting to be run. This has been a comprehensive piece of work with children and young people sharing their views and experiencing about what works well in their reviews and what they would like to be different of better. The Children in Care Council have now drafted a Review of Arrangements Expectations Statement, the aim of which is to improve children and young people's experience of their reviews and increase participation even further.

Some examples of the things young people have asked to be put in the statement are:

'If needed there will always be time for a short break. Our review meetings should never feel rushed'.

'There should never be any surprises in our meetings, we should be told in advance what is going to be discussed'.

It is planned that this will first be shared with the IRO Team and then ratified by the Corporate Parenting Board. It will then be shared with all looked after children, carers and relevant professions to be used as a bench mark of good practice. It is hoped that this document will be referred to, not least by children and young people, to help them feel empowered in attending their reviews and be reassured that their view should always be at the centre of the review process.

Updated Social Work Assessment Report available to the IRO 24 hours prior to the ROA:

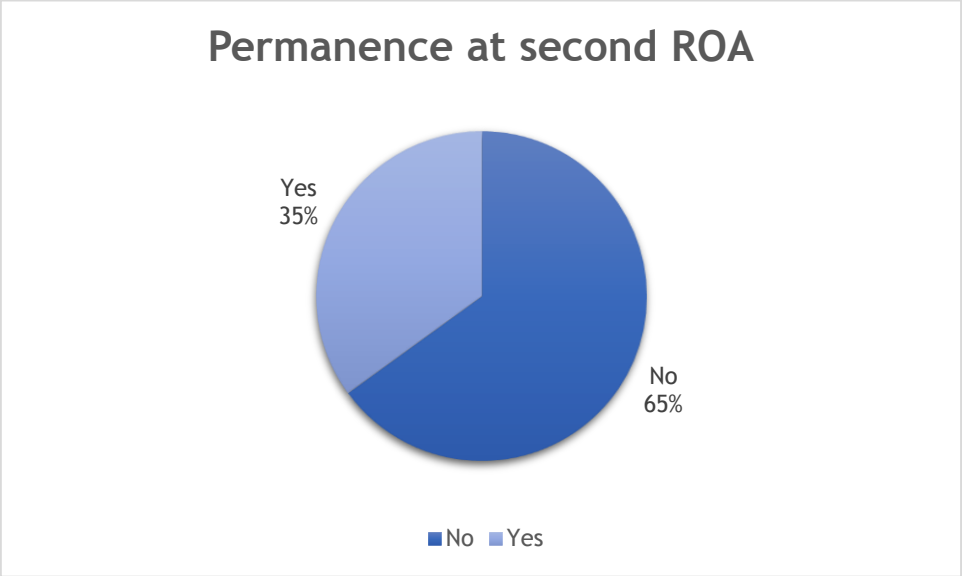
At the end of 2019/20 over a twelve month period 68.3% of Social Work assessment reports were available to the IRO 24 hours prior to the ROA meeting. This is a slight down turn from last year whereby 76% was achieved. This is still a considerable improvement over the rate for 2017/18 which saw only 51.1% produced within 24 hours of the ROA. As stated below this is one of the key concerns raised by IRO's in Quality Assurance alerts. IRO's value the importance of these reports not only as it enables them prepare for the ROA but it also provides key updates which the IRO can discuss with the child or young person to help them prepare for their own review and enable them to be more empowered within the review process. This will continue to be driven forward through the Quality Assurance Alert (escalation process) and further discussions with front line practitioners to highlight the importance.

Permanence

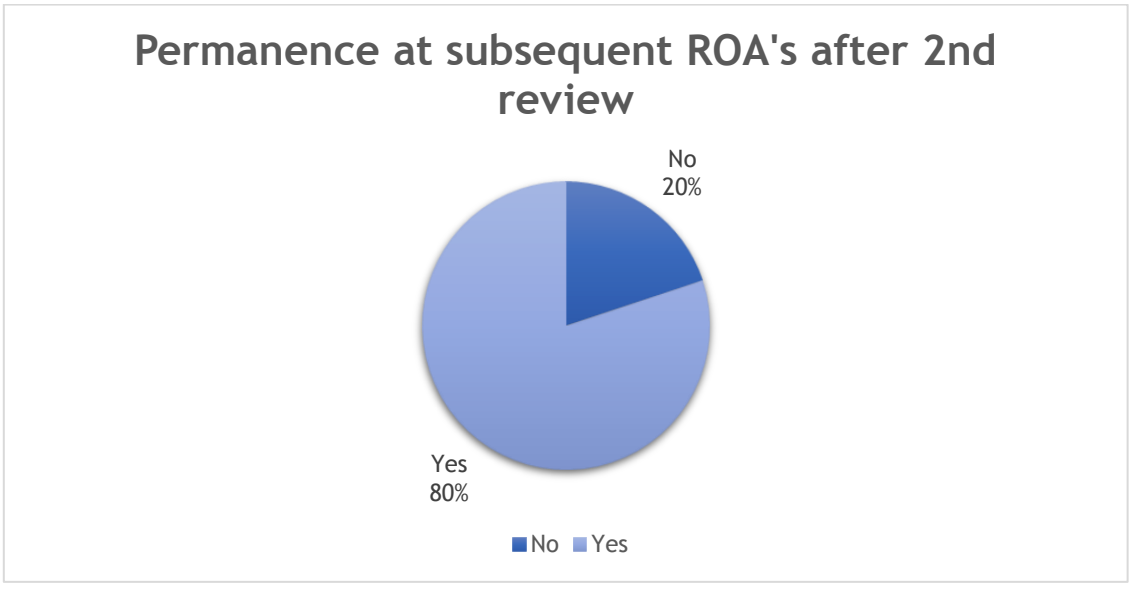
Permanence is described as the long-term plan for the child's upbringing. It aims to ensure a framework of emotional, physical and legal conditions that will give a child a sense of security, continuity, commitment, identity and belonging.

Securing permanence for children in a timely manner continues to be high on the agenda for IRO's and something which is routinely reviewed during ROA meetings. IRO's will arrange additional ROA meetings to be convened if there are concerns regarding drift and delay in respect of permanence and care planning as well as using the Quality Assurance alert and escalation process.

In between ROA meetings, IRO's will also endeavour to track cases and this is recorded on the child's file on Mosaic as IRO case tracking. The IRO 'footprint has developed significantly during the past four years. IRO's are ensuring they have oversight during review periods and addressing any concerns regarding drift and delay.



Statutory guidance for care planning states that there should be a permanence plan for all looked after children at the time of the second review of arrangements. In 2019/20 the Safeguarding Unit undertook 200 second ROA meetings and of these thirty five per cent, or 70 children and young people had permanence plans agreed at that time which. Unfortunately, there are lots of reasons why permanence cannot be agreed at the second review, which may include further assessments needing to be carried out to ensure that the right decision is made about a child or young persons future. At each review meeting IRO's discuss all possible options for a child's permanence and what actions need to be taken for these to be progressed. During 2019/20 it has been recorded that at reviews subsequent to the second review eighty percent of children had permanence plans.



Permanence planning is based upon the philosophy that every child has the right to a permanent and stable home. This means that the child has certainty about their

living arrangements and that it has been agreed that those who care for them will be able to meet their needs not only now but right through until they are ready to live independently. The role of the IRO is central to ensuring that matching permanence is considered and driven within the Review of Arrangement, minimising drift and delay. Decisions for permanence are made at the Permanence Panel which is chaired by the Head of Service for Children in Care. There is an increasing number of children being matched through Permanence Panel, but further work is being undertaken to ensure minimisation of any drift and delay and that permanence is a key priority for IRO's.

A priority consideration to permanence planning is to ensure that children are looked after for only the minimum necessary time, and where appropriate other legal orders such as a Special Guardianship Order (SGO) will be sought. This can be seen by many children and carers as a more preferable option as this offers legal security without ongoing involvement of the local authority.

In all appropriate cases this will routinely be discussed by the IRO at each review. IRO's will regularly discuss the potential for applying for an SGO and talk through any questions, worries or reservations that the carers may have, if appropriate the IRO will recommend that the family have a separate meeting with either the child's social worker or their supervising social worker to get more information about what financial, practical support and training they would be entitled to as part of an SGO support plan.

In 2020/2021 the IRO service will undertake more in-depth monitoring of permanence planning against the recommendation in the Continuous Improvement Plan, incorporating Tableau to gain greater insight into where all our children and young people are on their journey to permanence to ensure once a permanence plan has been agreed that there is no delay in this being achieved.

IRO Challenge & Escalation

Practice improvement and quality assurance is a central role for the IRO Service. Since September 2016, the Quality Assurance Alerts have been used by the IRO service effectively to identify areas of good practice as well as areas of concern, including quality and timeliness of reports, drift or delay in care planning, concerns regarding statutory duties not being met and areas of practice which need developing. As a service, we have routinely reviewed the Quality Assurance Alerts to help identify any key themes or areas which need to be addressed; this is then shared within the Senior Management Group.

From 1st April 2019 to 31st March 2020 there were 130 Quality Assurance Alerts completed in respect of children in care. Of these there were 41 for good practice and 89 highlighting areas of concern. This is an increase in the overall number of

alerts since the previous year by 37.7%, whereby in the previous year there was a total of 87 alerts raised 29 for good practice and 58 for areas of concern. Although it could be expected that there would be some increase due to the rise in numbers of looked after children, the main reason for this has been the greater focus the IRO Service has placed on quality assurance and improving outcomes for children.

The Safeguarding Unit has worked hard to embed Quality Assurance Alerts into practise and become part of Leicestershire's culture of continuous improvement. It is important that when an alert for concern is raised that these are written in a clear an objective manner that highlights any work that needs to be done whilst acknowledging positives and difficulties in achieving the right outcomes.
An example:

A QA Alert for concern sent to a team manager that commented on an assessment presented by a recently qualified social worker. The IRO began by highlighting much of the good work observed by the worker including their enthusiasm and commitment to getting the right outcomes for the children they were working with. The concern raised by the IRO was in relation to their assessment primarily focusing on the difficulties of the here and now and not the longer term impact. The IRO highlighted that in care planning it is essential to also consider the long term of impact of any issue or decision that is made. The Team Manager responded within the given timescale of 5 days and had actioned the concern by having reflective supervision with the worker and had specifically looked at how their assessment could be strengthened to include the longer- term impact. Creating more robust analysis and stronger decision making for the child.

IRO's recognise the importance of acknowledging good practice and ensuring this is formally recorded via the Quality Assurance process. Feedback from Social Workers and Teams indicates that the receipt of positive Quality Assurance alerts is very much welcomed and helps build on workers confidence, self-esteem, enabling them to be proud of their hard work and commitment to our children and families. It is pleasing to see that as the overall number of Quality Assurance Alerts has increased there remains approximately a third of these being completed for good practice. Good practice alerts are often to highlight where the good work of a colleague has made a real difference for a child or young person.

A recent example:

M, a fourteen year old girl who has been placed in a residential home for the first eighteen months of being in care. She had been keen to move into a foster placement and the IRO observed that it was the determination of the social worker to address a range of difficulties to ensure this was achieved at the earliest opportunity. This was raised with the team manager to acknowledge the efforts the social worker

had gone to and the difference it made to M when she finally got to move. M had said it was her dream to live with a foster family and the placement found was close to her school which was exactly what she was hoping for. It was also commented on that despite the added complications of the Covid 19 restrictions the move was still achieve just as the country was going into lockdown. The impact for M was significant and the recognition of the determination of the social worker in achieving this was important to share.

Quality Assurance Alerts for concern follow a 4 stage process, with the opportunity to escalate up the management structure if the concern is not resolved. Following the escalation process being completed, if the concerns remain, discussion will take place with the Assistant Director at the Challenge Meetings this enables the Assistant Director to have oversight on any cases where there are significant concerns as well as look at identified themes.

The Safeguarding and Performance service manager produces regular reports for senior management on the number of Quality Assurance Alerts completed and any themes that are identified. This is part of the department's Quality Assurance Improvement Framework. The feedback from the identified themes is welcomed by Senior Managers to enable us to continue to develop practice and improve the outcomes for our looked after children.

To strengthen the quality assurance process Quality Assurance Alerts have recently been built into Mosaic and linked to the Tableau information management system. This is a significant development in quality assurance and improvement work as it will enable IRO's and managers to track that all QA's are being responded to within the five day timescale, highlight any delays and identify any emerging themes or concerns far sooner and enable prompt action can be taken.

In addition to the local authority escalation process, if an IRO has any concerns about a child's care planning, which it is believed cannot be resolved by the internal escalation processes, it is the duty of the IRO to refer the case to CAFCASS. It is however, a procedure which is rarely invoked on a national basis. The Leicestershire IRO service has not referred any cases to CAFCASS in 2019/20.

For the IRO service to be effective it is essential that it retains its independence from the local authority's Children's Social Care Services. The management within the Safeguarding Unit are highly committed to the IRO's ability to exercise their independence and ensure that they have ready access to independent legal advice if the IRO wishes to challenge a local authority care plan, again this is rarely invoked, in 2019/20 although the legal advice of the local authority was challenged on a number of occasions by the IRO this was resolved internally with no applications for

independent legal advice, this compares with one application for independent legal advice in 2018/19. This could be seen as an example of the effectiveness of the escalation process and the commitment within the local authority to resolve issues at the earliest opportunity.

Challenge Meetings – IROs, Assistant Director (AD) & Agency Decision Maker (ADM)

The management group for the Safeguarding Unit meet each month for a Pre-Challenge Tracking Meeting, to discuss cases and themes of concern. It is then considered whether these cases / matters need to be taken to the Challenge Meeting with the Assistant Director for Children's Social Care, or if further actions can be taken in the first instance. A tracking spreadsheet is kept with a log of these discussions and the cases / themes are followed up with the allocated IRO during supervision or during Team Meetings if necessary.

Following the Pre-Challenge Tracking Meeting, the managers from the Safeguarding Unit meet with the ADM and Assistant Director monthly to discuss identified areas of concern. Cases discussed in this forum are cases which have followed the full escalation process. Given the quality assurance role of the ADM, particularly in respect of permanence, this working together forum is key to identify themes and areas of practice which need further development.

The increasing number of QA Alerts supports with greater oversight and scrutiny earlier in the process. IRO's discuss all QA's and cases of concern with their manager each month in supervision with a view to escalating to the Pre-Challenge process if necessary, however as the QA process has been further embedded during this period there are far more examples of issues being resolved promptly without the need for senior management oversight and intervention. Nevertheless, the role of the Challenge and Pre-Challenge meetings has proved vital in some of the most complex cases. Some of the themes that have been identified during 2019-20 have included: quality of Child Permanence Report and quality of Sibling Assessments resulting in drift and delay in care planning. The application of process for IRO's to endorse a Care Plan appropriately and timely and identification of cases where there could have been earlier challenge by the IRO. Utilising the challenge process has enabled oversight of the themes by the Assistant Director and actions to engage services to improve areas of concern. An example of how this has worked was the Safeguarding Managers attending all team meetings to go through the requirements of the IRO endorsing care plans and offering guidance and support. This has seen a much improved response limiting delay and ensuring robust oversight of decision making.

Children and Family Court Advisory and Support Service (CAFCASS)

The IRO service continues to maintain a good working relationship with CAFCASS Children's Guardians, at both IRO and management level. IRO's routinely liaise with Children's Guardians during Care Proceedings and ensure their views on the care plans are represented. Guardians routinely write to the Safeguarding Unit to confirm when they have been allocated a case under an Interim Care Order and are then invited to children's reviews. In addition to the liaison with the Guardian, the IRO also completes an IRO legal view on the proposed final Care Plan.

It is positive that CAFCASS management has expressed a strong commitment to continuing to build productive working relationships between IRO's and Guardians. During 2019/20 the IRO's and CAFCASS took part in a half day training and networking event to provide further insight in to each organisations roles and responsibilities and strengthen a shared understanding of the importance of good communication to achieve outcomes in the best interests of children.

Family Justice Board

The Safeguarding and Improvement Unit Service Manager attends the Family Justice Board meetings. This enables the IRO Service to have a direct connection into Family Justice Board and the Performance Sub Group of the Board. This assists with the IRO service being kept up to date with any issues arising from the Public Law work that in turn influences IRO practice. It also enables IRO's to continue to be up to date with changes to legislation, policies and procedures, enhancing their oversight of the practice and performance of the local authority in respect to children who are subject to care proceedings. This in turns helps ensure timely care planning and better outcomes for the children. The Service Manager ensures the IRO service is updated of key information via Team Meetings, emails and supervision.

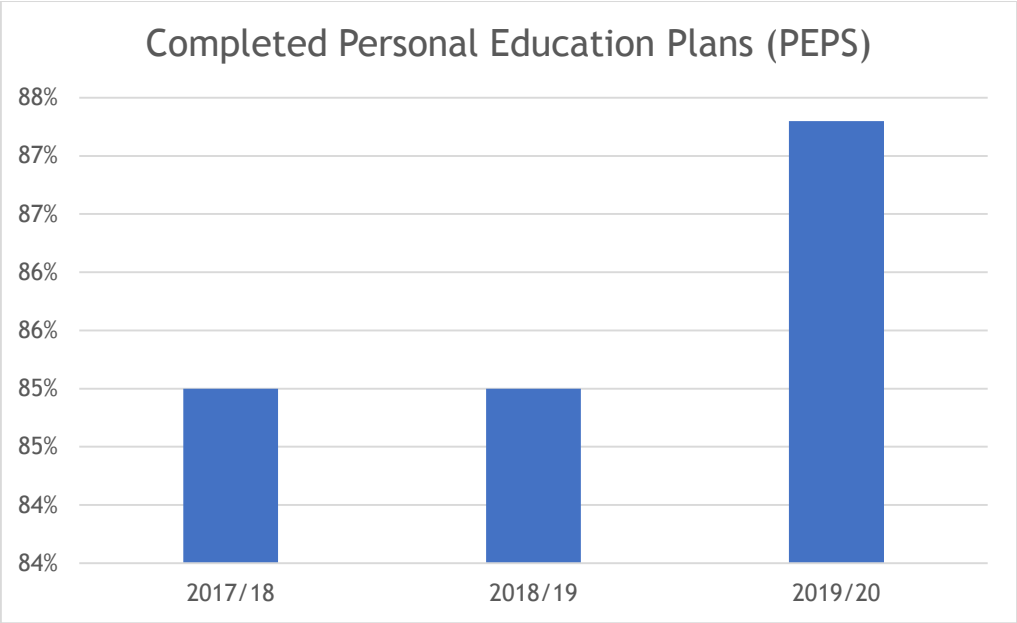
Regional IRO Forums

The IRO Service has continued to engage in the East Midlands Regional IRO forums and has had the benefit of quarterly tailored training and networking days over 2019/20. Each IRO Regional Day has a key theme running through the day with a variety of speakers delivering presentations as well ask there being opportunities to work in small groups with colleagues from other areas, to share good practice and reflect on ways to improve services for children and their families. Two such themes in 2019/20 were Participation and Planning. The first was looking at the ways different areas approach their work to enable young people to engage in their own reviews as well as contribute to the shaping of services through and range of engagement activities such as Children in Care Councils. There was a clear link with

the work of the Leicestershire Children in Care Council has undertaken as described in the participation section above.

The Planning day had a theme of developing plans with families rather than for families with an emphasis of building a shared understanding between workers and families with the plan being a positive piece of work which the families could take ownership of. The sharing of good practice on this day was particularly helpful in developing when reviewing Leicestershire's Child Protection Plans to ensure the initial plan was provided to the family within five working days.

Personal Education Plans

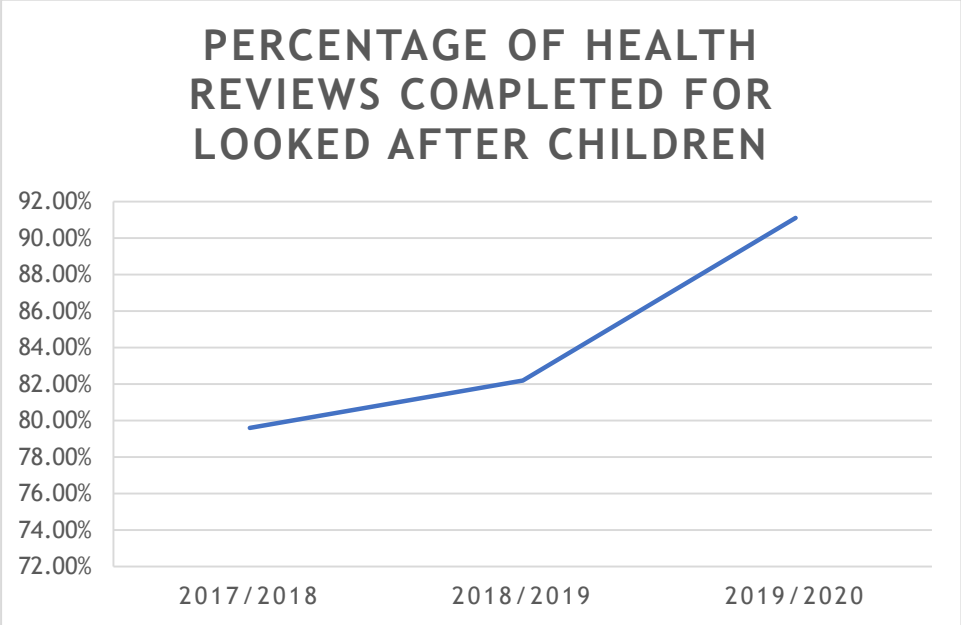


In 2019/20 of the 1418 looked after children that were eligible for a Personal Education Plan (PEP) 87% were completed, this is an increase from the previous year during which eighty five per cent of looked after children had a PEP recorded. At ROA meetings IRO's routinely confirm if PEP meetings have taken place, that all recommendations are being progressed and if this is sufficient or whether further actions are necessary. Completion of PEP's is a high priority as they are fundamental to ensuring each child has access to the right educational support to enable them to achieve their potential. To this end, IRO's work closely with the Virtual School, with the Education Improvement Officers regularly attending the child's ROA.

There are several reasons why a child may not have a PEP on file, one of the most significant being that they are not in school due to an unplanned placement move. With any unplanned move the IRO will undertake a 28-day ROA to ensure the right

steps have been taken to support the child in their new placement, including education provision. This has been an area of ongoing focus within the Safeguarding Unit in 2019/20 to ensure there is no drift and Safeguarding Managers have been reviewing caseloads with IRO's in supervision to identify any cases of ongoing concern where a young person is not accessing education and requires escalation within the Education Department through the Virtual School.

Health Reviews completed within twelve months



In 2019/20, of the 459 children who had been looked after for 12 months or more 91.1% have had theirs completed this is a significant increase from 2018/19 during which 82.2% were completed and in 2017/18 when 79.6% were undertaken. This is a very positive improvement which has been the result of the local authority raising the importance of health reviews across a range of forums including the Corporate Parenting Board.

Audits completed by the Leicestershire Partnership Trust for 2019/20 demonstrate high levels of compliance with GP registration, dentist registration, dental appointments, optician's registration and uptake of immunisations.

In 2018/2019 it was highlighted that the Strengths and Difficulties Questionnaire (SDQ), which looks at the child's emotional health and well-being should be a more integral part of the ROA process and a comprehensive action plan was developed and implemented in the final quarter of 2018/19. A recent audit showed evidence that this is now becoming embedded in IRO practice. It was found that IRO's are routinely demonstrating oversight to ensure that any children identified as needing

additional resources to support their emotions well-being are accessing the services they need.

Dental checks within a twelve-month period

As with health reviews dental checks are viewed with high importance in contributing to children and young people's well-being. In 2019/20 there were 407 (87.6%) of children who had a dental check within the last twelve months. This is an area which is routinely scrutinised by IRO's within the ROA's. The general expectation is that all children in care see the dentist every six months.

7. Independent Reviewing Officer: Child Protection Conference Service

Child Protection Conference Activity

The number of children that have been discussed at Initial, Transfer-in and Review Child Protection Conferences over 2019/20 was 2361 children which is an increase of 796 children from the previous reporting year.

Children discussed at ICPC

	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Child to be Subject of CP plan	68 88.3%	49 87.5%	61 87.1%	73 78.5%	42 85.7%	51 78.5%	69 79.3%	58 92.1%	48 76.2%	59 86.8%	52 88.1%	63 82.9%
No CP Plan required	9 11.7%	7 12.5%	9 12.9%	20 21.5%	7 14.3%	14 21.5%	18 20.7%	5 7.9%	15 23.8%	9 13.2%	7 11.9%	13 17.1%
Grand Total	77 100.0%	56 100.0%	70 100.0%	93 100.0%	49 100.0%	65 100.0%	87 100.0%	63 100.0%	63 100.0%	68 100.0%	59 100.0%	76 100.0%

In 2019/20 there were 829 children considered at Initial Child Protection Conferences (ICPC's) of which 133 (16.1%) had an outcome of no Child Protection Planning, this is an increase from the previous reporting year which stood at 8.1%.

Audit work has been undertaken to understand the increase and test the hypothesis that there is a changing threshold either within social work teams or with IRO's. The audit work has identified that the themes related to older children at risk of child exploitation, older siblings with different risks and children presenting with significant mental health difficulties increasing their risk. Whilst the audit did not identify a change in threshold it did highlight the need to consider a more consistent and specific response to these cases.

Numbers of Child Protection Plans

Numbers of children subject to child protection plans measured at year end (31st March 2020) have increased significantly from the previous reporting year:

2017-18	394
2018-19	388
2019-20	504

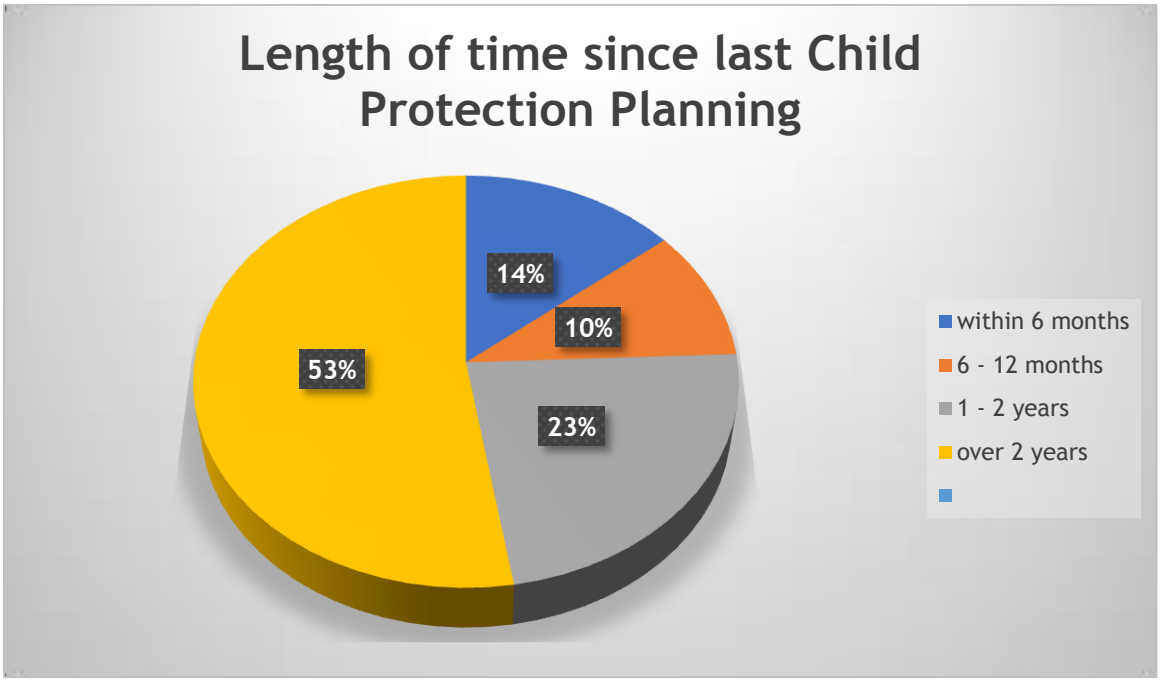
Repeat Child Protection Plans

In this reporting period the rate of children becoming subject to a child protection plans for the second or subsequent time has increased to 21.6% from 15.2%. As part of the Quality Assurance learning framework, audits of repeat plans have been completed in 2019/20 by a Safeguarding Manager, the key findings were that the repeat planning mainly centred around domestic abuse, the recurring theme being either that adults in relationships characterised by domestic abuse have either separated at the point of the Child Protection Plan ending but then resumed their relationship or a further relationship had started which was characterised by Domestic Abuse. In some cases, the safety plans and family networks have not been robust enough and had not been tested out over time

The role of the IRO is twofold in relation to improving the performance against repeat plans:

i) IRO's have oversight from the start to the end of the child protection process and are key to driving a plan forward. A key element of any plan is establishing safety, the IRO needs to ensure that the family network are fully engaged with the safety plan and that his has been tested throughout the child protection process. In 2020-21 there will be further work with IRO's on their role in pressure testing safety plans to ensure that they are established and effective at the point of a plan ending.
ii) IRO's have a quality assurance role in identifying themes both positive and negative and affecting change in practice. Repeat planning analysis has continued to be common practice for the Conference chairs, who are required to complete their analysis as part of their preparation for the Child Protection Conference. The IRO's are in a prime position to highlight and analyse concerns that have led to further child protection planning. This analysis and understanding will assist the IRO in setting out a robust plan with clear timescales to ensure that the needs of children and families are understood and comprehensively responded to, to prevent drift and delay or lack of progress for the family.

Of the 156 Repeat Plans that began over this reporting period please see below for the breakdown of months between Child Protection Planning;



Age at Repeat Plan Start by time since previous plan	Within 6 months	6 to 12 Months	1 to 2 Years	Over 2 Years	Grand Total
1 - 4	5	7	11	9	32
5 - 9	10	3	13	27	53
10 - 15	6	5	11	43	65
16 - 17	1	1	1	3	6
Grand Total	**22**	**16**	**36**	**82**	**156**

Plans Ending

Over 2019/20 the performance data showed that of the 607 Child Protection plans that ended in the reporting period, 121 (19.9%) of these ended at the first Child Protection Conference. This has increased from 14.4% in the previous reporting period, an explanation for this could be that since the last Annual Report, in Leicestershire we now consider ending Child Protection Planning at a child's 28-day

LAC review where the child is looked after, this is a multi-agency agreement. Outside of this process to end a child protection plan at the first review, Service Manager agreement is required to ensure robust decision making.

Length of Plans

Plans that have been in place for lengthy periods of time are also scrutinised to look at the effectiveness of the intervention and how robust the approach is in bringing about lasting change/permanence for children and young people.

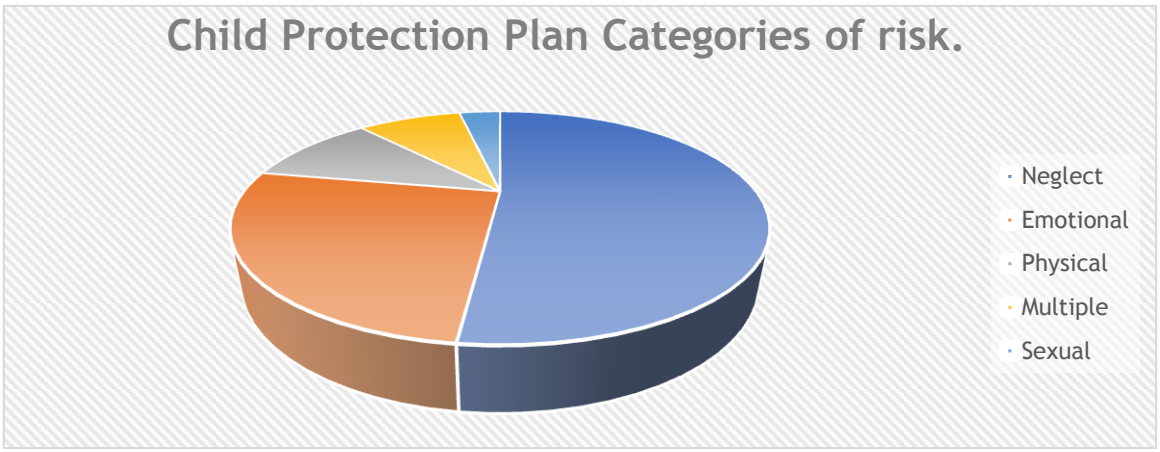
Over this reporting period there have been two audits to look at the cases subject to a child protection plan over 18 months. The audits were completed by one of the Safeguarding Managers. The findings of this Audit activity were that over time within this reporting period the number of Children being subject to Child Protection Planning for more than 18 months reduced, some of the main factors contributing to this were;

- Consistency of allocated workers i.e. social worker and Child Protection Conference chairs have not changed over this reporting period.
- There is evidence of management oversight by Team managers and Service Managers on some cases which have help to direct the case.

We now end Child Protection Planning for children virtually when they become looked after children, which means that there is more focus on a plan for a child rather than there being dual planning for children.

Child Protection Plan Categories of Risk

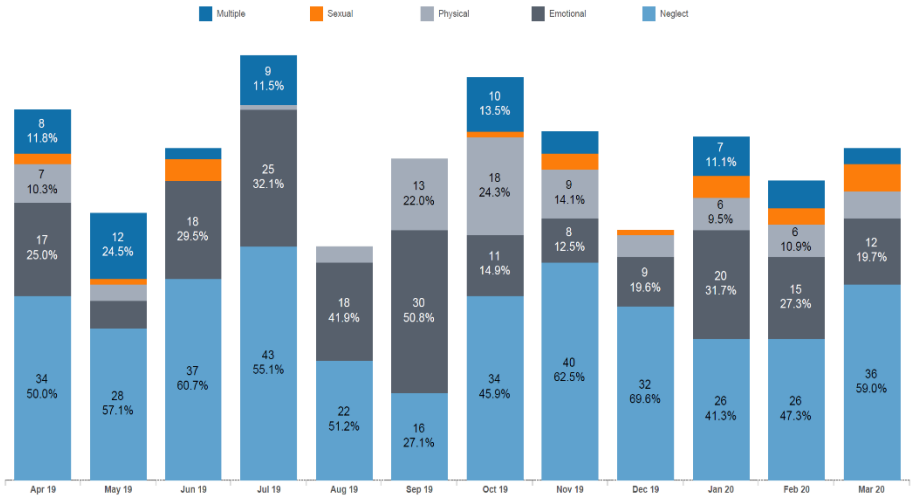
There are four main categories of risk that can be used as a determination of the primary risk factor for the child when subject to a child protection plan; neglect, emotional abuse, physical abuse and sexual abuse. In 2019/20 the breakdown of categories of abuse at the start of the child protection planning; Neglect 374 (51.9%), Emotional 188 (26.1%), Physical 75 (10.4%), multiple 60 (8.3%) and Sexual 24 (3.3%).



Categories at Start of Child Protection Plan

Date Range Selected Between 01/04/2019 and 31/03/2020

	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Grand Total
Neglect	34	28	37	43	22	16	34	40	32	26	26	36	374
Emotional	17	5	18	25	18	30	11	8	9	20	15	12	188
Physical	7	3		1	3	13	18	9	4	6	6	5	75
Sexual	2	1	4				1	3	1	4	3	5	24
Multiple	8	12	2	9			10	4		7	5	3	60
Grand Total	68	49	61	78	43	59	74	64	46	63	55	61	721



This data continues to highlight as it did in the previous annual report that neglect is the primary risk category. This can also be explained due to the definition for conference members for Neglect being broad, the definition is from Working Together document 2015 however it is not in the 2018 version,

"The persistent failure to meet a child's physical and/or psychological needs in a way that is likely to result in the serious impairment of the child's health or development,

Neglect may occur during pregnancy as a result of Maternal Substance abuse, Once a child is born, Neglect may involve a parent or carer failing to provide adequate food, clothing, shelter including exclusion from home or abandonment, failing to protect a child from physical and emotional harm or danger, failure to ensure adequate supervision including the use of inadequate care-takers, or the failure to ensure access to appropriate medical care or treatment. It may also include Neglect of, or unresponsiveness to a child's basic emotional needs"

Domestic Abuse is Leicestershire's highest reason for a contact and referral and during 2019-20 neglect was often used as the category of risk due to the definition containing '*failing to protect a child from physical and emotional harm or danger'.* Domestic abuse should be considered against all of the categories of harm and the most appropriate to the risks present used.

In the next reporting year there is significant work being completed on having a primary risk category and a secondary risk category. Ensuring the right category is used is central to developing a robust and effective plan to achieve positive change and outcomes for children and families.

Child Characteristics

The age range of children subject to a Child Protection Plan remains similar to the previous reporting year: -

Age	**Percentage of the child Characteristics subject to Child Protection Plan end**		
	2017/18	**2018/19**	**2019/20**
Unborn			0.8%
0-4 years	40.5%	43%	44.5%
5-9 years	30.5%	27.6%	26.8%
10-15 years	25%	26.6%	23.4%
16+ years	4%	2.8%	4.5%

The gender of children subject to Child Protection Plans for this reporting period remains the similar Female 48% and Male 52%.

The ethnic profile of children subject to Child Protection plans also remains consistent to previous years with 88% of children being of White origin and the remaining 12% distributed across Black and Minority Ethnic (BME) backgrounds with those of Asian/Asian British accounting for most.

Disability may be recorded as a Primary or Secondary Service User Group on Mosaic. Numbers have remained low throughout the year, at 31 March 2020 there were 3 children on a Child Protection plan with Disability recorded, compared to 5 at 31 March 2019. Low recording of disability is an area of consideration during monthly performance meetings and data quality work that is undertaken within services.

Conference Performance

For the reporting period 2019/20, there were 877 Child Protection Conferences 116 (13.2%) had been problematic from the perspective of having to go out of date or be stood down on the day and rearranged which is an increase on the (4.7%) reported in the last reporting year. When this happens, any learning is considered, and avoidable issues are taken up by the Service; for example, delay in social worker requesting the conference is addressed with their line manager, agency attendance is taken up with agency leads and Quality Assurance Alerts are considered.

The main reasons for conferences not being able to go ahead at the time are recorded in the table below;

Number of conferences having to go out of date or had to be stood down.	**Reason.**
3	Lack of an interpreter
27	Lateness in the request for an ICPC from the Social Work team.
11	Parent/carer not able to attend.
33	Lack of professionals in attendance – not Quorate
10	Social Worker ill / did not attend conference.
12	Unknown reason
4	Sickness with the Conference chair / Clerk
9	No clerk / IRO available
1	FII case lack of medical information to progress.
1	Should have been a receiving in conference in another LA, however did not go ahead.
1	Young person became upset during the meeting.
2	Gas leak at an area office.
2	Lack of information from the presenting LA.

The timeliness of Review Conferences over this reporting period was good with 93% convened within statutory requirements, which is a slight decrease to the last reporting period figure of 97.3%. This slight downturn was in response to capacity

issues within the safeguarding administration team in Quarter 1 of this reporting year. Decisions were made to prioritise Initial Child Protection Conferences as those coming to a review conference already had a plan had creating safety. Capacity issues were resolved during 2019-20 resulting in only a small reduction of timeliness.

Timeliness of Initial Child Protection Conferences remains consistently high at 95.2%, which is an increase from 91.5% from the last reporting period and in line with 2017-18. The table above highlights the many challenges to convening conferences in a timely manner. The achievement in maintaining good performance data in timeliness indicates the dedication and understanding of the importance for children and families to respond with the right action at the right time and minimise delay.

Conference Records

Distribution of child protection conference records during this period continues to be very timely, largely because of a collaborative approach with the team that provides administrative support for conferences.

The majority of records, along with a copy of the Child Protection Plan are distributed within 5-10 working days of the conference taking place. At the end of this reporting period 90% of records had been distributed within timescales. A copy of the mapping (the information completed on the whiteboard in the conference) is given to all attendees to take away with them at the end of the conference so everyone, including families, have a clear record of the strengths, concerns and what needs to happen to address the risk of harm to the children and young people concerned.

It is important to note the contribution from the clerks whose professional skill and diligence have ensured a continued high standard of recording.

The service strives to provide the same conference chair for all conferences for a family, when a child or young person has been subject to child protection planning and becomes accommodated into local authority care within this Child Protection planning period we endeavour, as much as possible, to keep the allocation with the same IRO as the family already know them and the IRO has knowledge of the child/ren's journey into local authority care. The child protection planning ends at the 28-day Review of Arrangements meeting following the agreement of all professionals involved with the child/ren, therefore preventing dual planning for children.

Social Work Conference Reports

In line with Leicestershire and Rutland Safeguarding Children Partnership procedures and Leicestershire's Practice standards, parents should receive the report for an Initial Conference at least 1 working day in advance of the conference and it should be with the chair 1 working day in advance. The report for a Review Child Protection Conference is to be with the parent and the Conference Chair at least 3 working days in advance of the Review Child Protection Conference.

Performance in this area has continued to evidence improvement; 79% of parents received the report before conference (75% last year), 16% on the day of the conference and 4% did not receive a report at all, this has increased 1% over the last reporting year. There is still room for further improvement and work continues to take place to ensure all parents receive the report within the expected timescales.

Agency Contribution & Participation

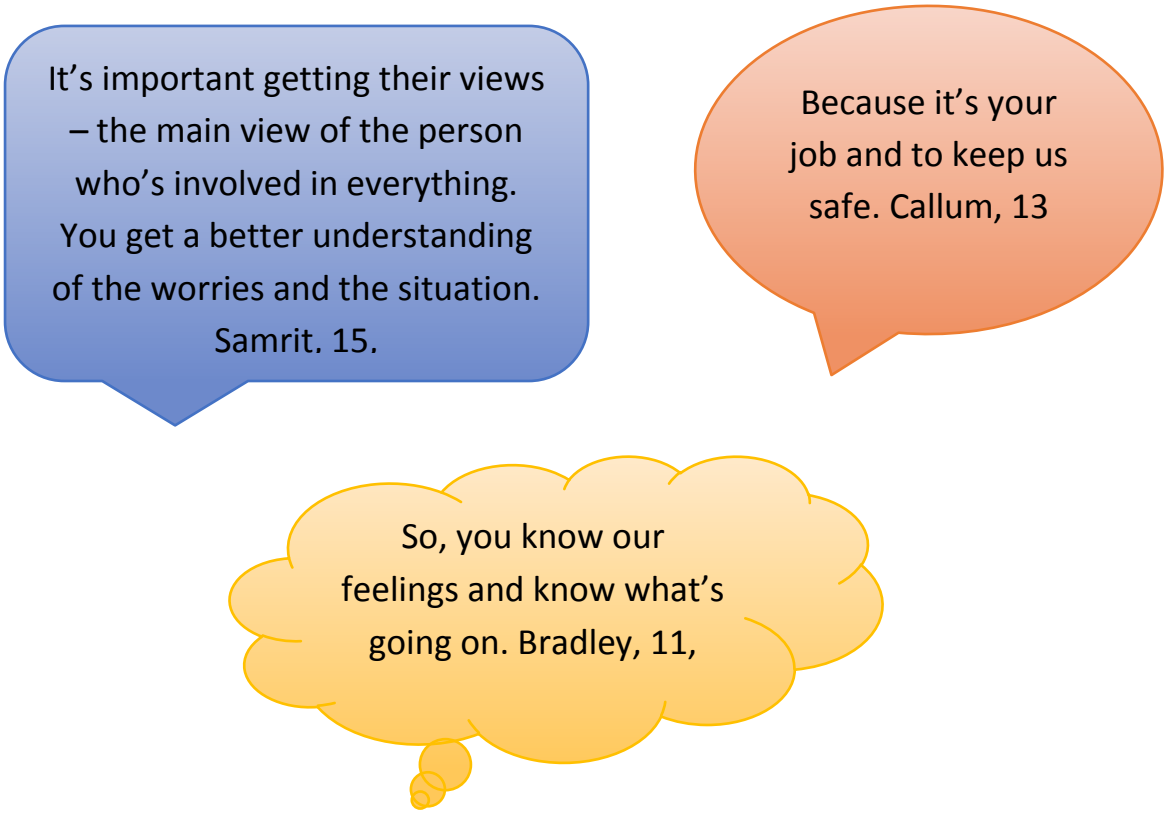
Following on from serious case reviews a task and finish group was developed to look at professional's attendance at Child Protection Conferences, providing of reports for Child Protection Conferences and professional attendance at core groups and to make recommendations for improvements.

As part of the meetings a new Multi-Agency Report to Conference was designed which incorporated some of the Signs of Safety methodology along with guidance for professionals as how to complete the form. The Multi-Agency Report to Conference and new practice standards will be developed over the next reporting year and signed off by Leicester Safeguarding Children Partnership Board.

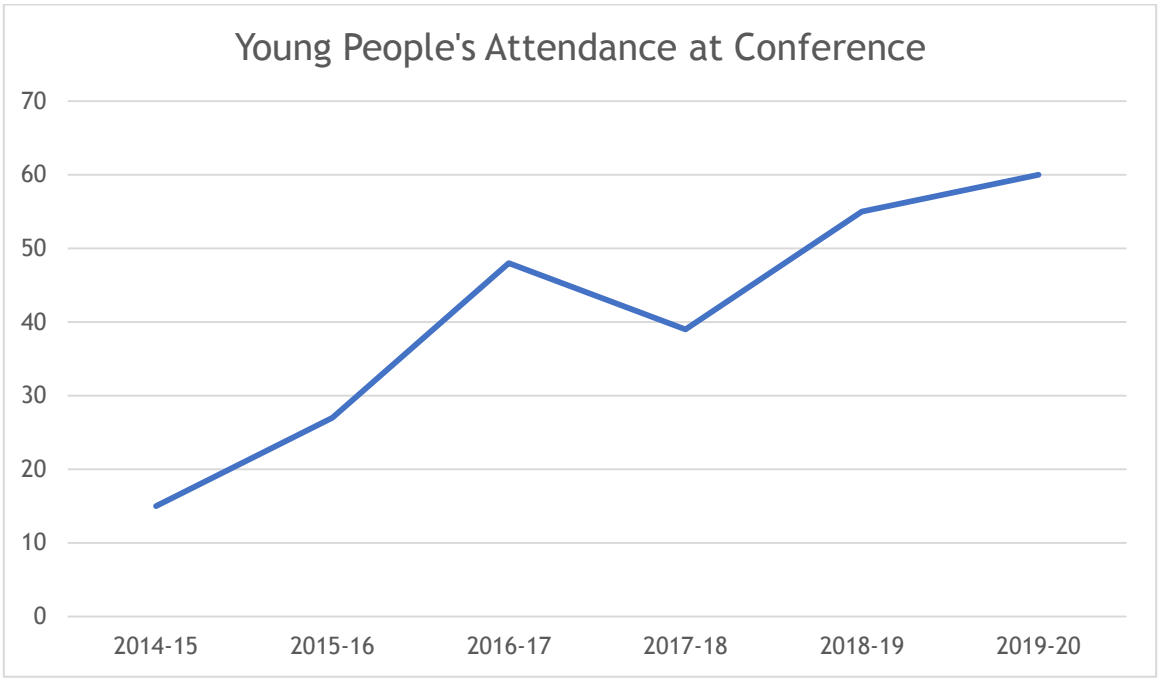
Attendance and contribution of children within their Child Protection Conferences.

One of the four domains that underpins Leicestershire's continuous improvement plan, "The Road to Excellence" is the importance of voice 'listening and responding to what the child and family tell us'. Within child protection conferences, the implementation of the strength-based Signs of Safety framework ensures a collaborative approach with families and recognises the importance of their voice being key to decisions. We have a comprehensive advocacy offer for children attending child protection conferences through our Children's Rights Service (CRS) which ensures that they are supported to attend if this is what they want to do, or their views are represented if they do not.

We asked children for feedback about their Child Protection conference meetings and when we asked them “whys should we listen to children?”



Most children and young people choose not to attend their conference. Nevertheless, during the reporting period there were 60 attendances of young people at their conferences which is an increase from 2019-20 and represents the highest figures since the CRS began supporting young people through the CP process. In addition the CRS attended or submitted a report for a further 146 conferences representing the child’s voice and view.



For those younger children who do not have the offer of advocacy the IRO (conference chair) will ensure that the voice of children is central to the child protection conference and the paperwork brought to conference supports the requirement for this to be captured and shared.

Completing the child protection conferences using the Signs of Safety framework ensures that the conference process is inclusive of the family and is completed with them. The impact for children and families is that they understand the worries and risks and feel valued and included to work towards achieving and maintaining change. It is evidenced that good relationship-based practice will improve outcomes for children and families.

Feedback from parents

J chaired it brilliantly, for what she has to deal with she manages it all

I am glad you are involved and I am glad that you are involving me, I am being a dad, you have given me a voice.

The way they managed the meeting made me feel part of it, they listened to me

The meeting was good, I feel that I understand what support I am going to get.

Leicestershire County Council

Feedback from professionals

"I have attended a couple of conferences that you have chaired now, and I have been really impressed with how you manage the meetings, the meetings have been very structured, and you always make sure that you explain things to parents in a really clear way and give them opportunities to share their views. In what can be a really difficult time for parents, you show empathy and compassion, both myself and my colleague who has also attended some of your meetings has also commented about your positive practice".

"The theme seems to be how thorough the conference chair is but today what stood out to me was how well she has put the mother at ease during an ICPC and taking into consideration how she would have felt throughout the conference. Mother was evidently very upset throughout the whole conference and I feel her approach was very friendly and sensitive and we were able to ensure the strengths for mother were highlighted a lot throughout the conference as the concerns were regarding mother's partner and not her care of the children"

The Chair [illegible] emotional and grandparents we[illegible] such calmness and empathy, it was so nice to hear his genuine compassion for the family. I was super impressed at his structure (as his planning was clear, in terms of areas and questions), his patience, his ability to involve all parties in the group, his language which was relatable, relevant and appropriate. i.e. non-judgemental and challenged when it needed challenging. I am so grateful that he got this case, as I think he really understood the family and respected them, whilst not minimising the concerns of the case. The chair was totally attuned to the family, and really dug for strengths to build upon, and you could hear his professional curiosity. His desire to help the family make this CP plan work was so evident that I know the family went away, although stressed with some hope for the future (as I did).

So basically, he was amazing, and he is an absolute diamond and credit to your team.

Challenges & Escalation

As referenced in the introduction and Children in Care section of this report, IRO's within the Safeguarding and Performance Service have a Quality Assurance role in identifying areas of concern in child protection practice and undertaking challenge where it is required. In 2019-20 75 Quality Assurance Alerts were completed for children subject to a child protection plan. 29 were for recognising good practice and 46 were an escalation of concern. The primary themes for escalation of concern was drift and delay and poor timeliness of receiving the social work report for conference. All themes are highlighted in the overview reports completed by the Safeguarding and Performance Service Manager and shared with managers to create effective action plans to improve practice. Quality Assurance Alerts for child protection are lower than those for children in care. This is a priority area for improvement to ensure progress against the key areas in the Continuous Improvement Plan. 2020-21 has seen developments for Quality Assurance Alerts in our reporting system Mosaic implemented. This will enhance both management oversight and performance reporting and improve engagement with the process.

Harmful Sexual Behaviour

The Notion of 'Harmful Sexual Behaviour' (HSB) has a dual concept of harm to others and harm to self. It is important that descriptions of HSB are contextualised about age and appropriate healthy sexual behaviour among children and young people. The Safeguarding Manager, leads on the development of the processes and response to HSB. Currently 3 IRO's are AIMS 2 trained and chair the initial HSB meeting and subsequent reviews.

A task and finish group made up of key managers and practitioners from CFS including HSB lead, specialist therapeutic worker, along with Police and Learning & Development representatives, continues to be utilised to develop the operational response to Harmful Sexual Behaviour (HSB).

Training is high on the agenda for the task & Finish group and following the introduction of the AIMS3 there is a drive for further training for certain people within the workforce to be able to complete the assessments. AIMS3 will assess all previous risks as well as Technology Assisted HSB and younger children, which was not available within the AIMS2 it is also a more developed assessment and includes a clear trauma informed focus which fits in with Leicestershire becoming a trauma informed authority, where clinical supervision is also a feature.

There have been further developments on Mosaic whereby following a Strategy discussion or single Assessment an HSB meeting can be convened, this will then go to the Safeguarding Manager and IRO will be allocated to chair the meeting.

Training & Workforce Development

Staff understanding of HSB thresholds has continued to improve over this reporting period. There continue to be different levels of training needs across the staff group; 'Brook's traffic light tool' basic training for all CFS staff, AIMS 3 training for experienced qualified Social Workers, AIMS training for managers supervising cases of HSB and 'good lives intervention model' for those practitioners who have completed the AIMS 2/3.

The charity 'Brook' has a sexual behaviour traffic light tool which can be used to distinguish different types of sexual behaviours at different age levels. It is also important to indicate what constitutes HSB when it's displayed by children or young people with a learning difficulty or developmental disorder which may have inhibited their sexual maturity.

AIMS is a nationally recognised risk assessment tool for children over the age of 10 years who are displaying HSB. The risk assessment assists practitioners to identify a suitable intervention programme. all AIMS assessment need to be completed by 2 staff to co-work cases, due to the complexities of the cases and its challenges when working with young people who engage in HSB's co-working provides and supports professional debate and the sharing of tasks.

AIMS 3 training will be made available for staff across CFS in this next reporting year, the main differences between AIMS 2 and AIMS 3 is that it considers technology assisted HSB and can be completed with younger children. AIMS training for Managers is designed to support line managers who supervise workers undertaking the AIMS 2/3 and intervention programmes with children and young people who display HSB.

There will be a greater push over the next reporting year from senior managers to have an equal spread of staff through all areas of CFS to complete the training, use their skills in AIMS assessing and develop an outcome plan. There will also be an expectation from the trained staff as they will be the HSB champions within their teams that they meet twice per year with Learning & Development, to complete peer audits on cases and reflect on practice.

Harmful Sexual Behaviour Meetings

Historically HSB meetings have been in the main one-off meetings. Development within the service has created a process for reviewing HSB that mirrors the processes of child protection. At the initial HSB meeting a safety plan can be put into place along with an action plan. This action plan is then reviewed until the group of professionals and family agree that the plan is as safe as it can be and that the family and professionals own this plan and adapt it accordingly for the HSB meetings

to come to an end. This process focusses upon the needs, risk and safety of the child(ren) and provides a framework where plans can be reviewed, amended and updated to ensure that the needs of the child are being met. HSB meetings are convened for children where HSB behaviours would be considered in the Brooks categories as being Amber/Red or Red behaviours.

It is important that the HSB meetings run alongside any other plans, such as child protection planning Child in Need Planning or care planning and that they inform each other, and there is not any further weight offered to any other plan.

Data reporting for HSB

Although there has been progress in development of performance reporting for HSB, this has been limited due to poor data quality and no current process to enable tracking cases that are Amber and do not require an HSB meeting. This is a development priority for 2020-21

What's working Well/ What are we worried about against our 2018/19 priorities

	2018-19	2019-20
Timeliness of ROA	98.9% (15/1388)	98.4(23/1430)
Participation in ROA	86.5% (1,049)	92.3%
Social Worker Assessment 24 hours before review	76%	68.3%
Repeat child protection plans	15.2%	21.6%
Multiple Categories (child protection plans)	10% (51)	8.3%
Review child protection conference timeliness	97.3%	93%
Initial child protection timeliness	91.5%	95.2%
Social Work reports to child	75%	79%

protection conference within LSCB timescales		

Recommendations 2020-2021

Quality Assurance

1. The Safeguarding Unit will be part of quality assurance activity to understand the reasons behind the increase in repeat plans. IRO's will continue to complete their analysis for repeat child protection conferences to support identifying themes and trends and share the learning as part of the systematic quality assurance cycle.

2. IRO's will be working to ensure that Safety Planning is both evident and tested in child protection planning to ensure that it is robust and embedded well enough to protect children once the child protection plan has ended.

3. Safeguarding Managers to support and drive increasing use of the Quality Assurance Alert process, identifying themes and supporting practice improvement within both children in care and child protection services. The role of the IRO is critical in ensuring that this process is robust and enables achieving the outcomes set out in the Continuous Improvement Plan.

Performance Reporting system

4. Development in Tableau (performance reporting tool) for the timeliness of records being completed and the completion of decisions and recommendations within 5 working days. To support management oversight and drive against this performance measure

5. Further development in the recording system 'Mosaic' and performance reporting tool 'Tableau', to enable performance reporting against the journey of all children with HSB identified at the point of contact with Children's Social Care.

6. IRO Service to work with Business, Intelligence & Performance team to improve reporting capacity of agency attendance at child protection conferences and then use this data to inform best practice approach with partner agencies.

Timeliness

7. Operational teams to evidence improved and sustained performance over 2020-21 in relation to timeliness/availability and quality of social work reports, updating assessments and plans for LAC Reviews and child protection

conferences. This will be achieved through effective use of the Quality Assurance Alert to highlight poor practice and celebrate improvements in terms of timeliness and engagement of children and families.

Multi-agency working

8. LLR SCP Child Protection Practice Standards will be implemented in 2020-21 and will provide a framework of expectations of all partner agencies involved in the child protection plan, improving full engagement in the process.
9. IRO Service to continue to work closely with CAFCASS over 2020-21 to ensure full and consistent application of the IRO/CAFCASS Protocol. Workshops and information sharing days to be utilised to further develop effective working relationships for positive outcomes for children and families

HSB

10. Training programme to ensure pool of AIMS3 trained workers to ensure comprehensive and effective offer for children presenting with Harmful Sexual Behaviour.

Voice and Participation

11. Further development in how we improve participation of our children in Review of Arrangement meetings following the work of our Children in Care Council on their 'Expectations Statement'. IRO's to ensure that this is considered against all elements of the meeting and that our children are central to planning. Also, the use of technology to be explored and implemented to improve participation

12. Contact Expectations Statement to be fully embedded and evidencing impact on contact experience for our children. Progress and expectations to be driven by IRO Service

Maintain good performance

13. IRO Service to consistently implement the process to systematically review cases of children subject to CP plan for 9 months and consider exit plan that will achieve maintained safety and permanence for children

14. IRO Service to maintain good performance in relation to timeliness of both initial and review child protection conferences.

15. IRO Service to continue to evidence consistency of chair for child protection conferences, as far as capacity will allow.

Kelda Claire

Service Manager, Safeguarding and Improvement Unit

Stuart Jones
Safeguarding and Improvement Team Manager: Performance and Corporate Parenting Lead

Kara Walne
Safeguarding and Improvement Team Manager: Safeguarding Lead

Sign off: Date

Overview and Scrutiny : Date